417 Reigert's Lane, Annville, PA 17003
Tel: 717-867-8335 Fax: 717-867-0340

AUTHORIZATION TO RELEASE OR RECEIVE CONFIDENTIAL INFORMATION

I, ____ DOB: ____________________________________
(Patient Name)

Request and authorize, ________________________________ to ☐ Release ☐ Obtain ☐ Exchange verbal information with:
(Name of provider)

Name: ____

Address: ____

City: ______________________________________ State: ___________________________ Zip Code: _________________

Phone Number: __________________________________ Fax Number: ____________________________________

To Release or Receive:

☐ All records ☐ Intake ☐ Diagnosis ☐ Treatment Plan

☐ Psychotherapy Notes ☐ Psychiatric Evaluation ☐ Progress Reports ☐ Summary of Treatment

☐ Lab Results ☐ Medications Prescribed ☐ School Records/Reports ☐ Alcohol & Drug Treatments

☐ Medical History ☐ Other (specify) ___________________________

It is understood this information will be used for the purpose of ____

____

I understand that my treatment records may include medical, psychiatric, alcohol or drug abuse information. I understand that my records are protected by law and cannot be disclosed without consent. I understand that I may revoke this consent at any time except for information that has already been sent. Unless I revoke it earlier this consent will expire in:

☐ **one year after the date entered below** ☐ **will not expire unless I withdraw my consent**

____ ____
Signature of patient (age 14 or older) Date

____ ____
Signature of custodial parent or legal guardian Date Witness Date
(Patient under age 14)

<u>To be completed if the patient is physically unable to sign:</u>

We affirm that ______________________________was physically unable to sign, but he/she understood the nature of the release and freely gave his/her verbal consent.

___________________________ ___________________________
Signature & Date of responsible witness Signature & Date of responsible witness